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MAR 13 1985
ALEXANDER L. STEVAS
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No. 84-1157 (2)

In the Supreme Court of the United States

OCTOBER TERM, 1984

NKC, INC., PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the Secretary of Health and Human Services correctly determined that the "Transitional Care Unit" of petitioner's hospital did not qualify for Medicare cost reimbursement at the rate for a "special care unit" under 42 C.F.R. 405.452(d)(10) (1977).

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-4a) is reported at 747 F.2d 1100. The opinion of the district court (Pet. App. 6a-14a) is unreported. The decisions of the Deputy Administrator, Health Care Financing Administration (Pet. App. 18a-31a) and the Provider Reimbursement Review Board (Pet. App. 32a-38a) are unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 5a) was entered on November 15, 1984. The petition for a writ of certiorari was filed on January 11, 1985. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE AND REGULATIONS INVOLVED

Relevant provisions of the Medicare statute and regulations are reproduced at Pet. App. 39a-47a.

STATEMENT

1. Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, establishes the Medicare program. Part A of that program authorizes reimbursement of institutional providers for medical care rendered to the aged and disabled. Providers receive reimbursement for the reasonable and necessary costs of the services they provide to Medicare beneficiaries. Congress has vested the Secretary of Health and Human Services with broad discretion to promulgate regulations governing the determination of "reasonable cost" for purposes of the Medicare program. 42 U.S.C. 1395x(v)(1)(A). Under the Secretary's regulations, 42 C.F.R. Pt. 405, Subpt. D, an average per diem cost is determined for services provided by a hospital. That figure is multiplied by the number of patient days attributable to Medicare beneficiaries in determining Medicare reimbursement. Since 1972, the regulations have distinguished between care provided in "routine care units" and that provided in "special care units." 42 C.F.R. 405.452. The average per diem costs for each type of unit are calculated separately; such costs normally are higher in the special care units than in routine care units.[1]

Fiscal intermediaries, which act as the Secretary's agents, perform the initial calculation and review of provider reimbursement requests. 42 U.S.C. 1395h. At the close of the fiscal year, a provider submits its cost report to the fiscal intermediary for review and audit. 42 C.F.R. 405.406(b), 405.453. A provider that is dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*. The Secretary or her designee may reverse, affirm, or modify the

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[1]This description of the reimbursement process applies to the period at issue in this case. Since that time, Congress has significantly revised the Medicare reimbursement scheme. See page 7, *infra*.

decision of the PRRB. Providers may seek judicial review of the agency's decision after the administrative proceedings have been completed. 42 U.S.C. 1395*oo*(f)(1).

2. Petitioner, the operator of Norton-Children's Hospital in Louisville, Kentucky, sought Medicare reimbursement at the special care rate for services provided by Norton's "Transitional Care Unit" (TCU) during 1977 and 1978. Petitioner's fiscal intermediary, Blue Cross and Blue Shield of Kentucky, Inc., determined that the TCU was not a special care unit within the meaning of the Medicare regulations, although it previously had been so classified. Petitioner appealed the intermediary's decision to the PRRB, which reversed the intermediary's determination (Pet. App. 32a-38a). The Secretary, acting through the Deputy Administrator of the Health Care Financing Administration, subsequently set aside the PRRB decision (*id.* at 18a-31a). The Secretary concluded that the TCU did not provide care that was "extraordinary," "concentrated," and "continuous" within the meaning of 42 C.F.R. 405.452(d)(10) (1977).[2] The Secretary interpreted that regulation as requiring that special care units provide care that not only exceeds that rendered in routine care areas of the hospital, but that is comparable to the high level of care provided by the units (*e.g.*, coronary and intensive care units) specifically enumerated in the regulation. Pet. App. 23a.

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[2]42 C.F.R. 405.452(d)(10) (1977) provided:

> *Intensive care units, coronary care units, and other special care inpatient hospital units.* To be considered an intensive care unit, coronary care unit, or other special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general patient care areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care

3. Petitioner sought review of the Secretary's decision in the United States District Court for the Western District of Kentucky. The district court upheld the Secretary's determination (Pet. App. 6a-14a). It held that the Secretary's interpretation of the regulation was not unreasonable and that there was substantial evidence to support the Secretary's conclusion that the TCU did not qualify as a special care unit.

The court of appeals affirmed (Pet. App. 1a-4a). The court concluded (*id.* at 4a) that it was within the Secretary's discretion to compare the TCU with the Norton coronary and intensive care units and to determine that the level of care provided by the TCU was not as high as in the recognized special care units.

ARGUMENT

The courts below correctly upheld the Secretary's determination that the Norton-Children's Hospital TCU does not qualify as a special care unit within the meaning of the Medicare regulations. This Court recently declined to review a petition for a writ of certiorari that presented questions similar to those presented by the petition in this case. See *Metropolitan Hospital* v. *Provider Reimbursement Review Board*, No. 84-506 (Jan. 7, 1985).[3] This case does not provide any new reason that would call for a different result.

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units but exclude postoperative recovery rooms, postanesthesia recovery rooms, or maternity labor rooms.

The petition refers to 42 C.F.R. 405.452(d)(10) (1972) and 20 C.F.R. 405.452(d)(10). See Pet. 4, 5, 10, 17. The provision at issue was not placed in 42 C.F.R. until 1977. See 42 Fed. Reg. 52826 (1977). When it was promulgated in 1972, the provision was codified at 20 C.F.R. 405.430(b)(9) (1973). See 37 Fed. Reg. 10354 (1972).

[3]We are providing counsel for petitioner with a copy of our brief in opposition in No. 84-506.

1. Petitioner's primary contention is that no deference is due to the Secretary's interpretation of 42 C.F.R. 405.452(d)(10) (1977), the Medicare regulation that describes the criteria for identification of special care units. However, Congress has delegated to the Secretary the authority to establish standards for the determination of "reasonable cost" for purposes of the Medicare program. 42 U.S.C. 1395x(v)(1)(A). In those circumstances, considerable deference normally is accorded to the Secretary's interpretation of the statute. See *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43-44 (1981); *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977). Deference is likewise due to an agency's interpretation of its own regulations. See, *e.g.*, *Ford Motor Credit Co.* v. *Milhollin*, 444 U.S. 555, 566 (1980); *Udall* v. *Tallman*, 380 U.S. 1, 16-17 (1965).

Petitioner urges that the Secretary's decision in this case should be subjected to especially careful scrutiny because she reversed a PRRB decision. But the Administrative Procedure Act, 5 U.S.C. 557(b), expressly provides that when an agency reviews an initial decision by an employee who has presided at an adjudicatory hearing "the agency has all the powers which it would have in making the initial decision." It is the final decision of the Secretary or her designee, not the initial determination by the PRRB, that constitutes the agency's authoritative interpretation of the statute and its own regulations. Petitioner itself acknowledges (Pet. 12) that the substantial evidence standard is not modified in any way when the Secretary disagrees with the PRRB.

Petitioner correctly notes that there is some disagreement among the circuits concerning the degree of deference to be accorded the Secretary's interpretation of 42 C.F.R. 405.452(d)(10) (1977). Six courts of appeals have upheld the

Secretary's interpretation,[4] while two appear to have rejected that interpretation insofar as it requires that special care units provide care that is equal to the high level of care provided by the units specifically enumerated in the regulation.[5] But to the extent the courts may differ concerning the precise formulation of the standard for identifying special care units, that disagreement appears to be of no practical importance. In each case, the courts have applied the substantial evidence standard to determine whether the unit at issue was sufficiently comparable to recognized special care units to satisfy the regulation. It seems unlikely that the outcome in any of the cases depended on the precise manner in which the court interpreted the regulation, rather than on analysis of the individual facts associated with the particular unit at issue.[6]

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[4] *Carraway Methodist Medical Center* v. *Heckler*, No. 84-7338 (11th Cir. Feb. 22, 1985); *St. Elizabeth's Hospital* v. *Secretary of Health & Human Services*, 746 F.2d 918 (1st Cir. 1984); *Lexington County Hospital* v. *Schweiker*, 740 F.2d 287, 290 (4th Cir. 1984); *Sun Towers, Inc.* v. *Schweiker*, 694 F.2d 1036 (5th Cir. 1983); *Psychiatric Institute* v. *Schweiker*, 669 F.2d 812 (D.C. Cir. 1981); *John Muir Memorial Hospital, Inc.* v. *Schweiker*, 664 F.2d 1337 (9th Cir. 1981).

[5] *Community Hospital* v. *Schweiker*, 717 F.2d 372 (7th Cir. 1983); *Saint Luke's Hospital* v. *Schweiker*, [1981-1982 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 31,501 (E.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982) (Table). Since *Saint Luke's Hospital*, the Third Circuit appears to have accepted in large part the Secretary's interpretation of the regulation in affirming an unpublished district court decision upholding the Secretary's conclusion that a particular unit did not qualify as a special care unit. *Metropolitan Hospital* v. *Provider Reimbursement Review Board*, 735 F.2d 1350 (1984) (Table), cert. denied, No. 84-506 (Jan. 7, 1985). See *Carraway Methodist Medical Center* v. *Heckler*, slip op. 2230 n.1.

St. John's Hickey Memorial Hospital, Inc. v. *Califano*, 599 F.2d 803 (7th Cir. 1979), cited by petitioner (Pet. 13-14), does not involve the "special care unit" regulation.

[6] For example, there does not appear to be any real conflict between the decision below and the two decisions in which courts of appeals have declined to uphold the Secretary's conclusion that particular units did

Even if there were in fact a conflict among the circuits on this point, it would not warrant this Court's attention. As petitioner acknowledges (Pet. 7-10), the Secretary promulgated clarifying regulations governing identification of special care units in 1980. Thus, the regulatory definition of special care units at issue in this case applies only to disputes involving cost years prior to 1980. Moreover, Congress recently amended the Medicare statute by completely revamping the manner of payment for most hospital services to covered individuals. Social Security Amendments of 1983, Pub. L. No. 98-21, Tit. VI, 97 Stat. 149 *et seq.* Under the amended statute, most hospital providers will be reimbursed on the basis of patients' diagnoses; the costs these providers actually incur will be irrelevant in computing reimbursement. The new prospective payment system is being phased in over the three years following October 1, 1983. See 42 C.F.R. 405.470 *et seq.* Accordingly, to the extent that identification of special care units may continue to be an issue, it will arise in a considerably different statutory and regulatory context from the one presented here.

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not qualify as special care units. The court in *Community Hospital* v. *Schweiker*, 717 F.2d at 375-376, held that the Secretary's argument in that case that a special care unit must treat patients who are critically ill and in immediate life-threatening situations was inconsistent with the regulation in effect during 1977 and 1978. There is no indication that the courts below relied on such a standard in this case. In both *Community Hospital* and *Saint Luke's Hospital* v. *Schweiker, supra*, the courts rejected any claim that a special care unit must provide care that is "identical" or "equal" to that provided in coronary or intensive care units. But in determining whether the units at issue in those cases qualified as special care units, the courts looked to whether the level of care provided was "comparable" or similar to that provided in recognized special care units. See, *e.g.*, *Community Hospital*, 717 F.2d at 376. Here the evidence showed that the level of care provided in the TCU was not comparable to that provided by the coronary and intensive care units at Norton-Children's Hospital. See page 8, *infra*.

2. The courts below correctly concluded that there was substantial evidence to support the Secretary's determination that the TCU did not qualify as a special care unit. In support of that determination, the Secretary cited, inter alia, record evidence that the level of patient monitoring in the TCU was considerably less extensive than in Norton's coronary care unit; that TCU patients did not need all the lifesaving equipment on a continuous basis that the coronary and intensive care patients needed; that the total nursing care hours per patient day in the TCU averaged 9.21, compared with 11.89 hours in the coronary care unit and 16.71 hours in the intensive care unit; that visiting hours for the TCU were considerably more liberal than visiting hours in the coronary and intensive care units; and that the written hospital policy stated that the purpose of the TCU was to serve patients found well enough to leave the coronary and intensive care units. Pet. App. 28a-29a. This evidence was clearly sufficient to support the finding that the TCU did not qualify as a special care unit.[7]

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[7]Petitioner notes that the district court quoted from the 1980 revision of 42 C.F.R. 405.452(d)(10), rather than from the 1972 version, and contends that the court of appeals "compounded" that error by approving retroactive application of the Secretary's interpretation of the regulation. Pet. 17. In fact, the court of appeals merely concluded that the district court's error was harmless, since the TCU did not qualify as a special care unit under the 1972 regulation.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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MARCH 1985

DOJ-1985-03